KENTUCKY HEALTH BENEFIT EXCHANGE ADVISORY BOARD

BEHAVIORAL HEALTH SUBCOMMITTEE

Meeting Minutes

February 19, 2013

Call to Order and Roll Call
The fourth meeting of the Behavioral Health Subcommittee was held on Tuesday, February 19, 2013, at 1:30 p.m. in the Small Conference Room at the Office of the Kentucky Health Benefit Exchange. Julie Paxton, Chair, called the meeting to order at 1:33 p.m., and the Secretary called the roll.

Subcommittee Members Present: Julie Paxton, Chair; Gabriela Alcalde; Dr. Edelson; Kelly Gunning; Dr. Stephen Hall; David Hanna; Kathy Lower (by phone); Jennifer Nolan; Sheila Schuster; Steve Shannon; Jordan Wildermuth; and Marcus Woodward (by phone). Nancy Galvagni and Susan Rittenhouse were not present at the meeting.

Staff Present: Carrie Banahan, Bill Nold, Lee Barnard, Miriam Fordham, Brenda Parker, Vanessa Petrey, Jill Mitchell (DOI), Kelly Kelly (DOI), and John Hord (DOI).

Approval of Minutes
A motion was made by Sheila Schuster to accept the minutes of the January 22, 2012, meeting with a correction to add Gabriela Alcalde in attendance by phone, seconded by Steve Shannon, and approved by voice vote.

Update on Exchange Activities
Carrie Banahan, Executive Director, Office of the Kentucky Health Benefit Exchange (KHBE), updated the subcommittee on Exchange activities. The KHBE prepared a draft of the Qualified Health Plan administrative regulation and posted it on the KHBE website for review. The KHBE received many helpful comments from insurers and is now working on a second draft of the regulation. The KHBE has also been working on a guide for enrollment transactions, referred to as 834 transactions, for individual market coverage that details the required information and format for enrollment reports for issuers. The KHBE will be meeting with issuers to discuss the guide. The KHBE staff has also been discussing design detail specifications in daily Joint Application Design (JAD) sessions. The Outreach and Education Subcommittee had a focus group of consumers that tested the recommended on-line screens for the Exchange to determine how understandable they may be for the average consumer. This exercise provided valuable input for the KHBE.

Coverage for Behavioral Health and Substance Use Services in the Large Group Market
Ms. Banahan noted that representatives from United Healthcare (UHC) Anthem, and the CO-OP were available at the subcommittee meeting to answer questions from the members. Because mental health parity requirements currently apply only to the large group market, insurers' schedules of benefits for large group markets were provided to the KHBE for the subcommittee to review. The Bluegrass Family Health (Bluegrass) schedule of benefits for the large group market was reviewed. There is currently no limit for inpatient and outpatient therapy documented in the schedule of benefits. There are, however, certain preauthorization requirements using medical necessity criteria. Plans can have medical necessity criteria under mental health parity. Many insurers use InterQual criteria for medical necessity determination. Marcus Woodward asked what type of medical necessity criteria Bluegrass uses. Ms. Banahan noted that the KHBE will follow up with Bluegrass to see what services they use for medical necessity determination for behavioral health.

Steve Shannon noted that the terms prior authorization and precertification were both used in the document and wanted to know the difference between the two terms. Marcus Woodward recommended that we obtain definitions for the terms. Bluegrass contracts with Optum Healthcare for administration of behavioral health and substance abuse services and members are instructed to contact Optum for all of their mental health services. Sheila Schuster commented that, while parity requires access to primary care providers should be the same for physical or mental health services, it appeared that a prior authorization was required for mental health services without a similar requirement for physical health services. The Optum representative noted that preauthorization and precertification may be the same thing, or it may differ, depending on the plan. Parity does dictate comparable processes for medical management, so that services on the medical side would dictate requirements on the mental health side. In most cases, preauthorization is only required for non-routine services.

Mental health benefits are included as part of the Essential Health Benefits, which are reviewed by the Department of Insurance. Ms. Banahan noted that there is disagreement between the U.S. Department for Health and Human Services (HHS) and the Department of Labor regarding the applicability of mental health parity to the small group and individual market, but HHS will be providing guidance on this issue in the near future. Bill Nold, Deputy Executive Director, KHBE, explained that parity applies to plan delivery rules on a high level. Members commented that if preauthorization was not applicable to physical health outpatient visits, then preauthorization should not be applicable to mental health outpatient visits either. The UHC representative noted that parity is assessed against the corresponding medical benefit, which may be difficult to ascertain.

Some members voiced concern about concern was voiced concerning whether there was sufficient time to review the plans. Chairman Paxton recommended that a work group be established to study the documents further.

The subcommittee also reviewed the United Health – Choice Plus plan, which included a certificate of coverage and a separate schedule of benefits. Ms. Banahan noted that items covered might vary slightly under the requirements for Essential Health Benefits (EHB). Prior

authorization is required only if medical plan has it. If it is not required for physical health services, then it is removed from behavioral health services. Several different guidelines including Milliman and standard practice are used to determine medical necessity criteria for behavioral health services and a similar methodology is used for physical health services. Ms. Schuster noted that there were co-pays and dollar limits, per day or visit, for mental health services, and asked whether there were comparable limits for the physical health services. The UHC representative stated that these limits applied to the small group markets, which do not currently require parity of services.

Department of Insurance Review Criteria for Mental Health Parity

John Hord, Department of Insurance (DOI), stated that small group market and large group market variability is often demonstrated in one document, and, thus, can be difficult to follow. The DOI reviews this documentation at rate and form filings. Jill Mitchell, DOI, stated that the DOI had a form filing meeting with insurers to review changes in the forms. The DOI is revising the checklists used for form and rate filing review in order to ensure that the Affordable Care Act requirements are met. The DOI currently compares physical and behavioral health limits, medical necessity and medical criteria, and lifetime and annual dollar limits. The DOI is currently reviewing for parity in the large group plans, but looking for additional guidance from HHS in this area.

Mr. Nold noted that there is variability in certificates of coverage and asked whether there is any explanation of this variability included with an insurer's form filing. Mr. Hord explained that there is a statement of variability required from the insurers in which the insurers have to detail the items that can be variable. Multiple plans and multiple products are filed within this one form. Ms. Banahan asked whether DOI would look at Kentucky's approved EHB from the Anthem PPO plan to be sure parity and all services are included. Ms. Mitchell replied that the DOI would review for parity including variability, ranges, amounts of co-pay and coinsurance, and actuarial value. Ms. Mitchell also noted that there is a draft calculator on the Center for Consumer Information and Insurance Oversight website that will determine the actuarial value of a plan with the appropriate input of information. Because each plan has to be actuarially equivalent to the HHS designated metal levels, variability should be reduced for qualified health plans.

Ms. Banahan asked whether the DOI reviewed the pharmacy benefit. Ms. Mitchell stated that the DOI reviews the drug counts. Under the ACA, insurers must cover at least one drug in each pharmacopeia category, and at least the same number of drugs as the benchmark plan in each category. Gabriela Alcalde asked whether medical necessity was included in each plan. Insurers include documentation of their source of utilization review criteria to DOI. It was noted that there does not have to be uniformity among the different plans, only uniformity within the plan. Consumers have a right to an external review by an unbiased, independent entity if a decision is unfavorable to the insured.

The subcommittee members also discussed medical necessity. Under the federal parity law, patients and providers can request and be provided a copy of the review criteria used in their determination at any time as this is a disclosure requirement. Medical necessity criteria are diagnostic and does not vary based on the plan, but may vary from carrier to carrier. Ms.

Mitchell noted that medical necessity criteria is not filed with the insurer forms provided to the DOI, but the utilization review agency used by the issuer is included in that filing.

DOI has asked that those insurers who wish to participate in the Exchange file their forms by April 1 and file their rates by May 1. Members expressed concern regarding having a sufficient number of mental health services providers. Ms. Banahan stated that Kentucky has an "any willing provider" clause in its statutes. However, DOI does not have the authority to force insurance companies to accept specific provider types for participation and reimbursement. Ms. Banahan noted that the KHBE has a contracted with Deloitte to conduct a study and provide an assessment on provider access within the state under the ACA.

Other Business
The next Behavioral Health Subcommittee meeting is scheduled for March 19, 2013, at 1:30 pm.

Adjournment
The meeting adjourned at 3:25 p.m.